

Political Culture of Health in India A Historical Perspective

This paper provides a historical perspective on the political culture of public health in India. It examines the genesis of the state's commitment to provide for the health of the people, but argues that in that original commitment lay numerous contradictions and fractures that help to explain the state's relative ineffectiveness in the field of public health. It argues that the nationalist movement's initial commitment to the state provision of welfare arose from a complex combination of motives – a concern with democracy and equity as well as concerns about the “quality” and “quantity” of population. The depth of ambition for public health was unmatched by infrastructure and resources; as a result, the state relied heavily on narrowly targeted, techno-centric programmes assisted by foreign aid. The paper also examines the malaria eradication programme as a case study which reveals the limitations and weaknesses of that approach; the ultimate failure of malaria eradication left a huge dent in the state's commitment to public health.

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...We should no longer be guilty of the neglect of the health of our people.

[M K Gandhi 1940]

Few nations have addressed the health needs of their peoples with such callousness and contempt.

[P Sainath 1996]

The Indian state since independence has spent a smaller proportion of its resources on public health than just about any other government in the world.¹ While the Indian state has been highly interventionist in many ways and spheres, the idea that the state ought to be held responsible for the provision of public healthcare is not one that has rooted itself in Indian political culture.² Public health, Amartya Sen and Jean Drèze argue, has been “one of the most neglected aspects of development in India” [Sen and Dreze 2002]. This essay attempts a historical explanation for that neglect.

India has, of course, experienced a significant and continuous lowering of mortality and a steady increase in life expectancy since independence. Life expectation at birth was estimated at 36.7 years in 1951; by 1981 the figure stood at 54 years, and by 2000, it was 64.6. The infant mortality rate fell from 146 per 1,000 in 1951, to 70 per 1,000 half a century later, although the decline in infant mortality slowed or stagnated during the 1990s.³ Yet it is clear that these gains have seen a highly unequal distribution across regions and across social strata. This very unevenness, furthermore, suggests that the improvements have not been the result of a comprehensive public health system of the kind envisaged by some Indians in 1947.

The trend of declining mortality coexists with persistently high levels of ill-health and disability. The Indian state acknowledged this in a recent report:

Given a situation in which national averages in respect of most indices are themselves at unacceptably low levels, the wide

inter-state disparity implies that, for vulnerable sections of society in several states, access to public health services is nominal and health standards are grossly inadequate.⁴

The state of India's public health services, suggest detailed analyses and anecdotal evidence alike, is dire.⁵ Even official sources lament that,

the presence of medical and paramedical personnel is often much less than that required by prescribed norms; the availability of consumables is frequently negligible; the equipment in many public hospitals is often obsolescent and unusable; and, the buildings are in a dilapidated state...the availability of essential drugs is minimal; the capacity of the facilities is grossly inadequate.⁶

‘Grossly inadequate’ is the constant refrain. This sense of hopelessness contrasts rather sharply with the confidence, the ambition and the sense of historic opportunity that pervaded public discourse about health around the time of India's independence. Buoyed by their acquisition of sovereignty and state power, the representatives of the Indian people set out to “wipe a tear from every eye”.⁷

A new utopia, a world without disease, seemed within reach. Nationalist and internationalist inspiration came together to suggest, for the first time, that health was – in the words of the World Health Organisation's 1948 constitution – a “right of every human being”. The idea that governments ought to provide healthcare for their citizens became an international norm. For their part, and having criticised the miserly neglect of welfare by the colonial state, Indian nationalist leaders participated enthusiastically in this new international order.

Yet I argue that the underlying contradictions in the intellectual, cultural and institutional forces shaping the Indian state's commitment to public health help to explain why it was both short-lived and inherently limited.

The first part of the paper suggests that when “national health”

began to emerge as a singular problem (and one which necessitated a singular response – national health policy), this happened in a way that was informed by distinct but overlapping concerns. The concerns of India's elite with racial purity and degeneration; the concern of social reformers with the misery of India's villages, and the concern of modernists with using the state to transform society and economy – drawing on the most “advanced” models then available – melded in sometimes contradictory ways to shape the political culture of health in India.

As a result of the confluence of these discourses, the idea that health as a right of national citizenship became thinkable, even natural, by the 1940s. Medical metaphors abounded in the rhetoric of the freedom movement, equating bodily health with national health, and the presence of disease with the sickness and decay of colonial authority. The claim to care for the welfare of the Indian people, in a way that no colonial government could do, was central to constructing the legitimacy of the post-colonial state.

I suggest, however, that post-colonial India was possessed of an inheritance which made it far from likely that the state would in fact hold the well-being of its citizens as its “first function”. Not only did the post-colonial state inherit a medical infrastructure that was weak, in some places completely absent, and a bureaucratic tradition that had never paid a great deal of attention to public health; it was also heir to currents of thought – both within and outside India – defining “well-being” exclusively in instrumental terms.

In the Beginning

In the 1930s, a cadre of modernisers in and around the Congress left began to think in terms of “national health”. By this they meant the health of “the Indian people”, a notion which was used interchangeably with the idea of the Indian “race”. As they came together to plan for the future of an Indian nation governed by an Indian state, the National Planning Committee (NPC) of the Congress made the shift from a colonial vision of India's races and peoples to one of a singular people and race. This transformation arose from the Indian nationalist movement beginning to “see like a State”.⁸ They believed, now, that India's diversity – a commonplace both of colonial and nationalist ideas of India – could become a source of strength if the state could manage, re-balance and govern it strictly.

Taken together with their discourses on the problem of planning and on the role of women in the future state, the NPC's report on National Health was nothing less than a reconceptualisation of what it meant to speak of “India's health”.

The modernists built upon, while appropriating for other ends, several strands of discourse about health, the body and the nation. The first of these was a historical discourse about India's poverty, a mainstay of nationalist thought from the 1870s which had, by the early 20th century, flowered into an economic critique of colonial rule. Despite widespread discussion of the colonial “drain of wealth” from India, the NPC seemed to believe, like so many others at the time, that poverty was in some sense a “natural” condition in India, and at the root of the problem of public health. “The root cause of disease, debility, low vitality and short span of life is to be found in the poverty – almost destitution – of the people”, they declared [NPC 1947]. Not only did poverty make individuals more susceptible to illness, poverty as a mass phenomenon weakened and undermined the Indian race itself: “the people of India in general are of poor physique, low vitality and short lifespan. They suffer chronically from certain common diseases and have their vitality undermined by frequent epidemics of a devastating virulence” (ibid, p 17).

The connection between poverty, under-nutrition and ill-health was particularly widespread at the time. Wrote the Planning Committee:

...something like 75 per cent or even more, of the incidence of physical disabilities other than those due to infectious diseases can be prevented by the provision of suitable food, adequate both in quantity and quality (ibid, p 38).

This line of argument brought together the seminal findings of the League of Nations' committee on nutrition about minimum human needs, widely circulated and debated in the 1930s, and the obsessions of Gandhi and other reformers with “diet and diet reform”.⁹

At the same time, however, the “low vitality” of the Indian people was blamed on institutions in the Indian society. Here, the NPC drew on and developed a discourse of social reform, reaching back to the debates about the “condition of women” in India in the early 19th century.¹⁰ A new level of public discussion about health and social practices formed part of the engagement, by India's elites, with the political, social and epistemological challenges posed by colonial rule.¹¹ Thus the NPC was quick to leap on the “social customs and institutions of the people” which, too, were “accountable for the low standard of public health in the country”. The “appalling ignorance of the masses”, the committee lamented, “and their religious and social prejudices make the introduction of scientific medicine into the country peculiarly difficult” [NPC 1947: 42]. The chief culprit was the “institution of premature marriages...common to all communities though usually denounced as the special curse of the Hindu society” (ibid, p 19). Drawing on, and developing, the widespread concern with marriage reform in late-19th and early-20th century India, the NPC declared that “we will have to depend on the spread of general enlightenment, and information about marriage hygiene amongst people, to make them adopt more healthy ways of life in such matters” (ibid, p 25).

Revealingly, the NPC envisaged a central role for a cadre of social workers, “imbued with a missionary spirit” in bringing about this transformation. “We shall have to create and depend on this missionary spirit of the various workers”, they declared, “by example and persuasion they will spread the gospel of healthy living, communal and personal, and thus take other villagers a step or two away from their age-long prejudices and superstition on the road to better living” (ibid, p 44). This illustrates the extent to which the radically modernist NPC had absorbed the culture of Hindu social reform, the idea that the self-disciplined “sevak” was the agent of transformation – as R Srivatsan has shown, in his article – who would “bring into being a new India” [Srivatsan 2006]. The Planning Committee expressed a utopian vision of “football and kabadi clubs for children, schools, libraries and dramatics”, all of them serving as a means to salvation, “preventing many urban dwellers from being driven to drink, gambling and immorality by offering attractive and wholesome substitutes” [NPC Population 1947].

However, linked to the discourse of social reform was a third strand of thought within the NPC's vision of national health: the question of the quantity and quality of the population. As Sarah Hodges has shown, concern with “marriage reform” translated, in the 1920s, into a flourishing Indian debate on eugenics [Hodges 2006]. The NPC made no secret of their belief in the “possibilities inherent in the carefully scientific breeding of the human race”. Worrying though the prospect of over-population was to the NPC, they were convinced that “cultivation of the race would have to be approached from an entirely different angle than from that concerning mere numbers” [NPC Population, p 7]. This was, they insisted, a democratic eugenics: there is “no reason”, they argued,

“why more attention should not be paid to improving the calibre of the race as a whole, and not only to particular classes or strata within it” (ibid, p 7). But the dark side was also clear for all to see: “a eugenic programme should include the sterilisation of persons suffering from transmissible diseases”. And the deeper implications were clear, leaving little to the imagination: “Caste has created the outcasts and contributes to make the problems of eradication of the defective types probably easier than in the west” (ibid, p 135). Feeding into this statement we can discern more than a century of upper caste anxiety about the reproduction of the “wrong sorts”.¹² This makes for uncomfortable reading, certainly, but underscores the point made by recent historical research; that eugenic thought was far from the preserve of the right, its sinister undertones fully compatible, in the radical nationalist imagination, with a belief in equality and democracy [Dikotter 1998].

It is important to bear in mind the complex and often contradictory ethical imperatives that underly the move towards planned public health policy, particularly since these contradictions were enshrined, unresolved, within the post-colonial state. The radical modernists within the Congress, Sugata Bose reminds us, were as driven by ethical imperatives as were the Gandhians [Bose 1997]. Examining the advent of planned health policy in India, we can see a heady mixture of ethical imperatives: democracy, self-reliance, concern with poverty, fear of degeneration, eugenics and a good deal of faith; faith in the potential for planned social transformation.

Significantly, Indian nationalists were well in advance of the colonial state in envisioning a thoroughly regulated, state-directed transformation of health conditions.¹³ Their vision of transformation went very much further than anything the colonial state could ever have conceived. Central to the NPC’s vision was a critique of the miserly colonial liberalism, which had left public health to the work of a small network of voluntary organisations, formed in the image of their Victorian counterparts.¹⁴ The NPC envisaged a future India where

Organised, systematic, collective enterprise to provide the necessary advice and treatment for guarding or improving the health of the individual is made available, not as a matter for the affected individual to obtain for himself, or even as a matter of spasmodic charity ... but as a matter of right to the individual through an organised public service discharging a common obligation of society towards its members [NPC National Health, p 27].

In their detailed proposals for a state-run health service, funded by a system of national social insurance, the NPC took their inspirations not from the colonial state, but from much further afield: from the maternalist welfare schemes of continental Europe [Koven and Michel 1990], from the liberal welfare state of New Zealand and, of course, from the Soviet Union [NPC National Health].

Strikingly, all of these were states whose “governmentalisation” was far in advance of India’s colonial government. Furthermore, none of them were “tropical” countries. Challenging the certainties of tropical medicine, which explained India’s susceptibility to disease in primarily environmental terms, the NPC invoked the universal standards of the League of Nations’ nutrition committee to declare that “the needs of the people... in this country are not different from the corresponding needs of the people in other temperate countries” [NPC National Health, p 39].

A National Health Service?

Only during the second world war, under duress, did the colonial state take up the more ambitious schemes for the transformation of India’s health services, discussed by the NPC in the 1938 and 1939.

Even while suppressing the Quit India movement brutally, with all the force at its disposal, the government of India turned to plans for post-war reconstruction to make a display of their concern for the “national welfare”, and to assuage key sections of the Indian elite [Pandey 1988]. This was a period, as Benjamin Zachariah has shown, when fundamental assumptions of imperial governance were undergoing a shift: the laissez-faire budget balancing of the past gave way to an interventionist colonial state [Zachariah 2005]. Health planning took place alongside a range of other plans for “post-war reconstruction” in industry, agriculture and social security, not least the Bombay Plan, its counterparts and rivals.

The circumstances of the war brought together, within the Bhore Committee, a combination of conservative ICS officers and international medical consultants, at least two of whom – Henry Sigerist and John Ryle – were openly communist in their views. Perhaps as a result of this unlikely meeting of minds, the committee was, for an “official” body, unusually open to new ideas. The thinking of the Bhore Committee owed much to its discussions with a group of international consultants, who toured India in late 1944 on a trip sponsored by the Rockefeller Foundation.¹⁵

The Bhore report, finally published in 1946, expressed its interest in widening the “conception of disease... by the inclusion of social, economic and environmental factors which play an equally important part in the production of sickness”. The committee went on to associate public health firmly with plans for economic development, suggesting that “unemployment and poverty produce their adverse effect on health through the operation of such factors as inadequate nutrition, unsatisfactory housing and clothing and lack of proper medical care during periods of illness”.¹⁶

The Bhore Committee was implicitly critical of the prior neglect of public health by the colonial state (even though the report began with a conventional narrative of the beneficent medical progress which British rule brought to India), the more so in their confidential correspondence with the government. A memorandum by the British advisors to the committee declared that “the Provinces... are jealous of an autonomy in respect of public health, medical relief and medical education, which they are not as yet strong enough in personnel or material resources to wield”. Similarly, they were critical of the prevalent attitudes of the civil service: “there is a too widespread attitude of apathy of defeatism: (i) because the problems are so vast; (ii) because the political situation is so difficult and uncertain; and (iii) because of the frequently reiterated lament that ‘India is a poor country’”.¹⁷

In making its case for a national health service, the Bhore Committee cast its net wide, examining, in detail, plans for post-war health services in Britain, the US, Canada, Australia and New Zealand, as well as making frequent reference to Henry Sigerist’s admiring account of the development of Soviet health services in the 1930s [Sigerist 1937]. The Beveridge report was a clear and explicit influence, throughout. This was a significant departure from the perspectives of the 1930s, which had suggested the need for a completely different approach to health in poor agricultural (and, of course, colonial) countries to those of advanced industrial societies. Based upon this comparative view, the Bhore Committee suggested that “the comprehensive conception of what a community health service should undertake has led to the development of modern health administration, in which the *State makes itself responsible* for the establishment and maintenance of the different organisations required for providing the community with health protection”.¹⁸ This was the most striking departure from prior colonial practice, and it also reflects the extent to which the Bhore Committee’s proposals were foreshadowed

by the Congress' NPC. At the centre of the Bhore Committee's proposals for a national health service was the 'Three Million Plan', a national network of district health centres linked to more specialised centres of medical care in larger urban areas.¹⁹

The terms set by the Bhore Committee left a lasting legacy. In many ways they remain the yardstick against which many commentators and health activists judge the government's subsequent efforts to be wanting.

Means and Ends

At the moment of independence, the value of public health was well-established in Indian political culture; but it was a deeply contested value. Within the thinking of the Congress Planning Committee health was, at once, a basic human right, a tool for the improvement of the "Indian race", making it more efficient and more governable, and health was an instrument for economic development. The need for public health stemmed from an egalitarian commitment to welfare, and from a far-from-egalitarian fear of the rising numbers of the lower castes.

Furthermore, there remained a wide gulf between aspirations for the improvement of public health, and the absence of the ability to bring this about. The serious crises of the 1940s revealed just how fragmented and weak India's health infrastructure really was.²⁰

For reasons too familiar to need recounting here, the Indian state after Partition focused on the consolidation of its hold over sovereignty and territory, in the process retaining much of the institutional architecture of its colonial predecessor. Thus public health – relatively inessential, in the view of the new nation-builders, compared with military security or industrialisation – remained primarily the responsibility of the states, without the funding to match.

A number of participants in the constituent assembly debates highlighted the need for the new state to reinforce its commitment to public health with concrete guarantees of resources. K Santhanam from Madras, pointed out that the provisions in the proposed constitution for funding public health were manifestly inadequate: "if you take Public Health, according to the Bhore Committee report, it requires 300 crores", he declared, which was, at that time, the "total of the provincial and central taxation".²¹ In a debate the following year, Renuka Ray of West Bengal invoked the Chinese constitution to argue for a constitutionally guaranteed minimum of funding for public health (and education): she suggested between 15 and 30 per cent of overall expenditure.²² For his part, Hirday Nath Kunzru expressed unease with the proposal to retain the current division of responsibility for health and welfare between the centre and the states; a division which had served India poorly in the past. In a post-colonial era, Kunzru argued, "central government powers to give effect to international agreements" – agreements, that is to say, specifying minimum standards for public health, nutrition and welfare – "should be wider than it is at present".²³ Yet these voices were in a minority. There was, in the end, relative consensus that, in the Constitution, public health ought to be a directive "principle of governance" rather than a fundamental right.²⁴

In this context, the availability of external resources for public health was positively welcomed by the government. Even before independence, the interim government of India exhibited a keen interest in the new World Health Organisation (WHO), in the process of establishment as an arm of the United Nations.²⁵ Unlike its predecessor, the League of Nations, which had focused primarily on Europe, the WHO indicated from the outset that

its resources would be available to all. The organisation's constitution declared, boldly, that "the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition". Furthermore, the constitution acknowledged that "unequal development in different countries in the promotion of health and control of disease, especially communicable disease, is a common danger" [WHO 1948].

The appeal of the new international institutions to the Indian state was obvious. And Nehru said so quite clearly, before the first meeting of the WHO's south-east Asian regional committee, in Delhi, in 1948. Nehru declared that "India attaches the greatest importance to the work of the WHO, more especially from the point of view of south-east Asia, which was very backward in health conditions". Suggesting that in the past, "world organisations directed their activities more towards the problems of Europe or America", Nehru drew on the fear of epidemic diseases in order to justify priority for Asia in the new organisation's work. He claimed that: "It is well known today ... that one cannot isolate any part of the world and make one part of it healthy and leave other parts unhealthy, because infection spreads. The world must be tackled as a whole, and in doing so backward areas must be tackled first".²⁶ It was an effective speech. The language of entitlement – India, as a sovereign nation, was entitled by right to the latest international technologies of health; DDT, antibiotics, x-ray machines – alternated with the language of fear: Nehru drew on deeply-rooted western fears of India as a source of contagion, as an epidemiological heart of darkness. In the climate of the cold war, this was an effective strategy for the Indian state. India deployed external resources in its quest to provide public health, above all in its quest to eradicate malaria.

'A New Era of Health and Happiness'

The development of malaria control policy in the 1950s encapsulates, in many ways, the political culture of public health that evolved after independence. This is, not least, because at its height, between 1959 and 1963, the national malaria eradication programme took up nearly 70 per cent of India's budget for communicable disease control, itself accounting for nearly 30 per cent of the overall health budget under the second plan [Jeffery 1988]. India quickly became the world's largest market for DDT. The malaria eradication programme was heavily dependent on outside funding: between 1952 and 1958, the US contributed more than 50 per cent of the cost of the programme, and nearly 40 per cent of the cost of the eradication programme between 1959 and 1961 (*ibid*, p 200).

The national malaria control programme – which subsequently set its sights on malaria eradication – epitomises the political culture of public health in the "high-Nehruvian" era, and it points to the contradictions and the weaknesses inherent in the Indian state's approach to public health.

Within the public discourse on malaria eradication as a goal of state policy, we can see the contention and overlap of earlier narratives of public health.²⁷ First, there was the redemptive narrative of public health as the relief of suffering, and liberation from bondage to malaria. The initiative was characterised by ambition and excitement; malaria eradication – like planning itself – was a great adventure. The sense of mission and of opportunity comes across clearly from the memoirs of D K Viswanathan, India's foremost malariologist at the time [Viswanathan 1958]. Viswanathan wrote of his "worship at the

altar of science", in the service of the people. Need justified ambition; the results would transform the country:

...the success of such a programme in a continent of the size of India and the saving of sickness and death amongst the world's largest population [were] sufficient incentives for the programme being undertaken without allowing oneself to be detracted by difficulties which can certainly be overcome with determination... (ibid, p 29).

Just a year after the national malaria control programme began, the state issued a statement that encapsulates the redemptive thrust of the campaign. Malaria control had brought the "relief of human illness and suffering [that] has changed the face of the country", the report declared, and "a new era of health and happiness is dawning for the people living in erstwhile malarial tracts".²⁸

It was precisely this promise of liberation that the Phanishwarnath Renu satirised in his novel *Maila Anchal*, published the very year the national malaria control programme began. The protagonist, the doctor, goes to the village of Maryganj filled with missionary fervour, he "wanted to serve mankind, to find the causes of diseases that destroyed human life, to invent a new medicine that would wipe out bacteria, and leave all of mankind healthy and strong".²⁹ Yet the doctor confronts, in a climactic moment of despair, the enormity of the problem of public health, and its inextricable link with the poverty of the village. "What good did it do for those who felt pity for them to make up long lists of vitamins and distribute them?" the doctor wondered. His experience convinced him that

People who came here trying to alert the villagers to the dangers of malaria by showing slides and writing preventive procedures on wall posters with pictures of mosquitoes might as well be from another planet! Villagers looking at the posters would make comments like, "People are wasting their time trying to give Purnea District a bad name for mosquitoes...Look at what enormous mosquitoes they have in the West! Those mosquitoes have bodies as big as your hand, and a stinger four hands long! My God!"³⁰

On this view, the redemptive narrative of malaria eradication was hollow, as long as mass poverty and social inequalities persisted. "It must be the life-giving black soil of the fields that keep the people alive", the narrator declared, "but soon, they might lose the right even to set foot on the soil!"³¹

Alongside the redemptive narrative of malaria eradication, however, stood a militarised, disciplinary narrative that presented malaria eradication as an assertion of the state's power, its technology and its sovereignty. The emphasis, tapping into the emphasis on personal and national discipline in the debates of the 1930s, was on centralisation and obedience to authority; public health as responsibility of the citizen. The malaria eradication programme found ritual expression in a way that underscored the state's presence in the lives of its citizens. To commemorate "World Health Week" in 1955, for example, "two planes of the Indian Air Force dropped leaflets" on malaria eradication on Hyderabad and Secunderabad [*The Hindu* 1955]. In this case, the commemoration of international public health was wedded to a dramatic assertion of the state's presence, through its Air Force planes, just seven years after Hyderabad was subject to forcible incorporation into independent India by "police action".

Perhaps the most prominent justification for the malaria eradication programme, however, was an economic one. The dominant narrative was developmentalist in tone. Wrote *The Hindu*:

In India anti-malarial campaigns, undertaken with WHO assistance, have been successful. There has been an increase in the population of the Terai region and the area under cultivation has gone up 40 thousand acres. Equally striking successes are claimed in the

eradication of malaria in some of the most deadly hotbeds of the disease in Burma (ibid).

Spraying with DDT was a means of making land cultivable and releasing labour for the modern industrial economy. Indeed, malaria eradication would cement the space of the "national economy" itself, making the space of production congruent with the space of state sovereignty, removing "natural" obstacles to cultivation. The invocation of the Terai region signifies an escape from the tropics, for it had been notorious in the colonial imagination as representing the lethality of the Indian environment. The Terai, David Arnold has shown, was once "almost defined by death. This tract was considered so deadly as to be impassable for Indians and Europeans alike through a large part of the year" [Arnold 2005]. The key was to be able to show that malaria eradication would allow for an increase in food production, at a time when, from east and west, alarm grew about the global "population explosion".

This was the reason invoked most frequently by the state and by international organisations – malaria control would increase agricultural productivity.³² In the end, this argument proved fatal for malaria eradication. When it could not be shown that malaria control was transforming agricultural productivity, particularly as the Indian economy moved towards agrarian crisis in the 1960s, or when other interventions – viz, population control – seemed more "cost-effective", support for malaria control ebbed.

The success of the malaria control and eradication policies must not be under-estimated. Indeed, the success was quite staggering. Malaria, perhaps the leading cause of mortality and morbidity at independence, had virtually disappeared by the late 1950s.³³ The Indian anti-malaria campaign was undoubtedly the world's most extensive. By 1958, a total of 8,704 malaria squads were in operation – a dramatic indication of the expansion of malaria control from a few pilot projects – and the spraying of a total of 438 million houses was complete. The statistics, however problematic, tell an astonishing story. The number of recorded cases of malaria fell from 75 million in 1951 to just 50,000 in 1961. The malaria eradication programme employed 1,50,000 people by 1961. By that year, malaria cases accounted for less than 1 per cent of all hospital admissions, an astonishing diminution in the burden of malaria [Spielman and Antonio 2002]. It is important to bear in mind that though the eradication programme failed, with a significant resurgence of malaria in the 1960s, the incidence of the disease has never since reached the levels where it stood in the 1940s.

Yet, the malaria eradication campaign did begin to falter, in the 1960s, because of the absence of health infrastructure and, on some views, because of resistance to DDT and to anti-malarial drugs. Reliance on technology (DDT) was a consequence of the weakness of India's health infrastructure at the moment of independence. The success of DDT, in the end, depended upon a level of medical surveillance that was noticeably absent in India. An active programme of "case-finding" constituted a crucial final stage in malaria eradication; Indian conditions made this very difficult. After the initial campaign of intensive spraying, to eliminate the anopheles vector, malaria control teams needed to find all infected persons in an area and treat them with anti-malarial drugs to eliminate the human reservoir of plasmodia before the mosquitoes could return.

The "active case finding" in India was the responsibility of surveillance officers, each paid three rupees a day. The work, one international malariologist conceded, was "even more tedious and repetitive than the job of the sprayman", and there was evidence that teams routinely avoided villages far from the main roads, and "concealed [this]...by taking an excess of blood samples from families more easily reached" [Harrison 1978]. Passive case finding

by hospitals was no more promising. Gordon Harrison, who worked with the WHO on global malaria eradication, observed a public health system inadequate to the task, with tales of hospitals forgetting to order microscope slides, and doctors ignoring the “routine” tasks of surveillance: “what struck the visitors as probably symptomatic of similar failures elsewhere was not so much the technician’s forgetfulness as the doctors’ unconcern”. Such was the state of rural health services that “by the time a reasonably prompt report came that a particular individual was infected, he might have left his village or because of a false or ambiguous identification at the local clinic have become untraceable” (ibid, p 252).

In 1961, there were fewer than 1,00,000 cases of malaria in India. Between 1961 and 1965, the number of cases jumped to 1,50,000, and then doubled again within a few years. The Indian government itself concluded, in an investigation into the resurgence of malaria in the country, that:

We can see that in those states where the rural health services are well developed, such as Mysore and Kerala, reversions have not occurred, and the maintenance is kept under good control even in areas previously hyperendemic. In other words, the map of reverted areas can be super-imposed on those with delays or imperfections in the development of the rural health sector.³⁴

Mysore and Kerala are, in a sense, the exceptions that bring into sharp relief the prevalent political culture of health in most of India: a culture of apathy and neglect, one in which public health fared poorly in the competition for political attention and funding. As is well documented, Kerala presents a history quite different to that of much of south Asia; one in which the “universal” campaigns of disease control and eradication were matched by a sustained, and deeply politicised, effort to build up local institutions.³⁵ Health, in mid-20th century Kerala, was championed as a “people’s right” in a way almost without parallel in the region.³⁶

A further point worth raising is that, to the extent that disenchantment with DDT was an additional factor contributing to the collapse of the malaria eradication programme, the potential risks of its continued use were decided not in India, for the most part, but elsewhere. Sharma and Mehrotra have argued that “resurgence of malaria could not be contained...mainly because of want of insecticides rather than their failure”.³⁷ At a crucial point in the eradication programme, in 1963, the USAID stopped providing DDT to India, in the wake of domestic debates in the US concerning the safety of DDT, following Rachel Carson’s seminal publication, *Silent Spring*. Indian authorities had, thereafter, to purchase DDT from the Americans under a long-term loan agreement, and were constrained in this by straitened foreign reserves; at the same time, domestic supplies of DDT proved “less than reliable”. The position deteriorated after 1965, when American aid decreased significantly, following the India-Pakistan war. Given the energy and the resources poured into the malaria eradication programme, its fragmentation dealt a serious blow to the cause of public health in India.

I am not suggesting that the Indian state should have intensified its assault on malaria using DDT in the 1960s – whether or not they should have done so is a matter for debate, and certainly the toxic effects of DDT are all too real. There is an argument that malaria control would make such an overwhelming difference to the lives of hundreds of millions of Indians that the ecological risks are relatively smaller; countering that is the belief that there ought not to be double standards as to what constitutes an acceptable level of risk in India as opposed to the west. Both arguments have force. My point is, rather, that the political culture of public health in post-independence India worked against wide public participation in such discussions at the time. As public health was turned, increasingly, into a simple instrument for the furtherance of the

state’s broader ends, so questions of health retreated into the realm of expertise, with a consequent decline in the scope and extent of public discussion of health. The reliance on external resources for the malaria control programme compounded the problem.

At the same time, the dominance of the “vertical” malaria control apparatus throughout the 1950s led to a consequent neglect of general health services, while establishing a pattern that continues to this day. The government of India’s most recent national health policy reflects, honestly, on this legacy:

...the government has relied upon a “vertical” implementational structure for the major disease control programmes. Through this, the system has been able to make a substantial dent on reducing the burden of specific diseases. However, such an organisational structure, which requires independent manpower for each disease programme, is extremely expensive and difficult to sustain.

The report proceeds to suggest that such programmes may “only be affordable for those diseases which offer a reasonable possibility of elimination or eradication in a foreseeable time-span”.³⁸ The ultimate cost of this approach was the patient, unglamorous task of building up local health services.

As early as the 1960s, the pioneering research conducted by the National Tuberculosis Institute in Bangalore, underscored the costs of neglecting local health services, showing the weakness of health services in the face of the serious problem of tuberculosis. Criticising the tendency by the Indian state and by the WHO to blame the failure of public health programmes on the “non-compliance” of patients, a sociologist at the Bangalore institute wrote: “the Indian villager does not need to be told in words about the tuberculosis problem, but needs a service to deal with a problem which...is only far too well known to him”.³⁹ The problem did not lie in “native ignorance”, and the solution did not lie in instrumental “health education”. The problem was deeper, and lay in the lack of confidence that prior experiences of many Indians’ with the public health services had engendered in them. “People who now feel ill” he continued, needed the confidence that that “they will be taken care of as well as medical technology can currently manage”, and “people who fear that they or their dear ones might become ill” ought to have the sense that “should catastrophe strike”, that it could, and would, be cured (ibid). This remains a distant goal.

The Ends of Public Health

Paradoxically, perhaps, the very richness of the ethical values underpinning the origins of national public health in India helps to explain its weakness. I have argued here that the nationalist commitment to public health drew on a complex, sometimes contradictory, range of imperatives, from a commitment to universal rights and radical economic reform, to fears of the proliferating numbers of the poor and an increasing worship of the modern state.

As Sudipta Kaviraj has argued recently, the ambition of the nationalist movement made it almost inevitable that they would have to rely on the “ubiquitous instrumentality of the state” to bring about change, given the extent to which the British colonial government had neglected health, social welfare and economic development.⁴⁰ Kaviraj’s description of the outcome still rings true, 15 years after he penned it: the state became “wholly monological, criminally wasteful, utterly irresponsible and unresponsive to public sensitivity” [Kaviraj 1991]. This is an apt description of the story of public health in post-independence India, and helps explain its mounting neglect of public health. As Sugata Bose has argued about development policy more broadly, it has been a story of the instruments becoming an end in themselves, and trumping the fundamental idioms, or values, of health.⁴¹

The culmination of the tendency, wherein the state treated the health of the people as a simple instrument towards its broader goals, came at the point when population control emerged as the dominant and overwhelming goal of “health” policy. Mohan Rao has shown with great clarity how the agenda of population control in India came to “dominate concerns in the field of health and contoured the directions of health policy”. The First Five-Year Plan, he shows, “envisaged demographic change as a dependent variable responding to wide-ranging shifts in social-structural factors”; by the time of the Second Five-Year Plan, in 1956, the government appeared to believe that “population growth is an independent variable and economic change the dependent one”. By 1961, and the third plan, the shift was resolutely in favour of population control.

A major shift came, Rao argues, when a UN advisory mission convinced the Indian government, in 1964, that the IUCD could be used on a massive scale, thus overcoming the problems faced thus far in the proven unpopularity of the “rhythm” method, and the dangers attendant on surgical methods. The central government undertook to fund population control activities in the states (even as they refused to cover the costs of their public health apparatuses), and from 1966, family planning was created as a separate ministerial responsibility, granted almost as much in funding as the entire public health service of India. In Rao’s words, family planning in India has “damaged the growth of health services in the country”.⁴² The state admits as much, declaring in 2002 that: “the rural health staff has become a vertical structure exclusively for the implementation of family welfare [for which, read “family planning”] activities”, with the result that “for those public health programmes where there is no separate vertical structure, there is no identifiable service delivery system at all”.⁴³

From a historical perspective, the reason India proved so receptive to the international missionaries of population control are deeply rooted. They lie, I believe, in the legacies of late-colonial debates on health and the body. The shift to population control was, in a sense, immanent in the political culture of public health; in the sexual, racial and caste-based anxieties underlying the Indian nationalist movement’s discussions of health, and in its privileging of the centralised state as the prime instrument of change. The language Indira Gandhi used in early 1976, justifying coercive population control in a speech to Indian physicians, draws on a long tradition of nationalist thought:

We must now act decisively and bring down the birth rate. We should not hesitate to take steps which might be described as drastic. Some personal rights have to be held in abeyance for the human rights of the nation: the right to live, the right to progress.⁴⁴

However radically different the political context, these sentiments would not have seemed alien to the National Planning Commission in 1938. “The importance of deliberately controlled numbers”, they pleaded, “cannot be exaggerated in a planned economy”.⁴⁵ And, again,

Where population is increasing by leaps and bounds, and where poverty increases in the same proportion, control of population is absolutely necessary. From the eugenic point of view, the Indian stock is definitely deteriorating for want of proper selection as well as due to poverty, malnutrition, etc, factors which are detrimental to the nation’s health.⁴⁶

The inextricable connection, in nationalist thought, between the desire to control (economic) production and (human) reproduction provide an underlying thread linking malaria eradication and the shift towards population control. Yet this article has attempted to show that the nationalist commitment to public health was not *only* motivated by such anxieties, but also with the aspiration to construct a centralised state. The history of public health in India

since 1947 shows an inextricability of ethical imperatives and technical solutions. In this case, the governmentalisation of the state (its legitimisation by caring for the welfare of the population) has coexisted with the continuing weakness of the state, and its inability to secure welfare for the people. In such a situation of indeterminacy, the fundamental values of public health can come into play as tools in political contest. The language of sacrifice, the redemptive or even messianic narrative of public health as personal and social liberation never disappeared; Harish Naraindas has shown it to have been very much at the forefront during the smallpox eradication programme of the 1970s [Naraindas 2003].

Political activism in the field of health has not been absent in India. It has, however, often gone unheard, not only by the state, but in the mainstream media – public protest has all too frequently been reduced to what Mohan Rao calls an “unheard scream” [Rao 2004]. Recent years have witnessed halting, but hopeful, moves by a range of groups to make health, once again, a subject of public debate. Such groups seek to turn the promise of the right to healthcare into a properly political demand for its provision. This is most notably the case of the Jan Swasthiya Abhiyan, which declares that:

We reaffirm our inalienable right to and demand for comprehensive health care that includes food security; sustainable livelihood options including secure employment opportunities; access to housing, drinking water and sanitation; and appropriate medical care for all; in sum – the right to Health For All, Now!⁴⁷

This demand is the more powerful for drawing on precisely the language of rights and promises which the post-colonial state made to the people on the eve of its foundation. It is enriched with reference to broader international norms – the WHO’s constitutional declaration of the right to health, and its later commitment to “Health for All”. Over a longer period, the work of groups like the Medico-Friend Circle have sustained an activist political commitment to public health, challenging the state’s attempt to turn public health into a purely technocratic realm of expertise and utilitarian calculation.⁴⁸

In one of his last works, Pierre Bourdieu reminded us that “as soon as principles of universal validity...are stated and officially professed there is no longer any social situation in which they cannot serve at least as symbolic weapons in the struggles of interest or as instruments of critique” [Bourdieu 2000]. So it remains of the “right to health” in India, even in these bleak, neo-liberal times. **EW**

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Notes

[In memory of Rajnarayan Chandavarkar (1953-2006).

In preparing this article I have benefited from the insights, advice and criticisms of the late Raj Chandavarkar, Angus Deaton, J Devika, Mohan Rao, Emma Rothschild and Helen Tilley. I bear sole responsibility for the contents of the article and any mistakes or misunderstandings it may contain.]

1 UNDP, *Human Development Report, 2004* (New York, 2004), pp 156-58; UNDP, *Human Development Report, 2005* (New York, 2005), pp 236-40.

The 2005 *Human Development Report* shows that health spending accounted for only 1.3 per cent of the Indian government’s expenditure in 2002 (the figure in 2001 was 0.9 per cent), a level that is amongst the lowest in the world.

2 Cf Pratap Bhanu Mehta, *The Burden of Democracy*, Penguin 2003, New Delhi.

3 Figures from L Visaria, ‘Mortality Trends and the Health Transition’ in T Dyson, R Cassen and L Visaria (eds), *Twenty-First Century India: Population, Economy, Human Development and the Environment* (Delhi 2004) and Government of India, *National Health Policy (NHP)* (2002).

4 Government India, *NHP* (2002).

5 See, for example, essays in *Seminar*, 489, May 2000; P Sainath, *Everybody Loves a Good Drought* (Delhi 1996); G Shah, *Public Health and Urban Development: The Plague in Surat* (Delhi, 1997); A Krishnakumar, ‘An

- Unhealthy Trend', *Frontline* (November 10-December 3, 2004). A recent local study, of rural Bengal, is the *Pratichi Health Report*, Pratichi Trust, Kolkata, 2005.
- 6 Government of India, *NHP* (2002).
 - 7 The phrase, of course, is Gandhi's. See Sudipta Kaviraj, 'In Search of Civil Society' in Kaviraj and S Khilnani (eds), *Civil Society: History and Possibilities*, Cambridge University Press, Cambridge, 2001, pp 287-323.
 - 8 Following J C Scott, *Seeing Like A State: Why Certain Schemes to Improve the Human Condition Have Failed*, Yale University Press, New Haven, 1998.
 - 9 On Gandhi's use of the League of Nations reports, see my *Decolonising International Health: India and Southeast Asia, 1930-65*, Palgrave 2006, chapter one.
 - 10 Lata Mani, *Contentious Traditions: The Debate on Sati in Colonial India*, Berkeley and Los Angeles 1998; Janaki Nair, *Women and Law in Colonial India*, Delhi, 1996.
 - 11 For a particularly lucid account, see Sudipta Kaviraj, 'Ideas of Freedom in Modern India' in R Taylor (ed), *The Idea of Freedom in Asia and Africa*, Stanford 2002, p 117.
 - 12 For a lurid contemporary example, see U N Mukherji, *Hindus: A Dying Race*, Calcutta 1909. For further discussion, see Mohan Rao, *From Population Control to Reproductive Health: Malthusian Arithmetic*, Delhi, 2005, pp 263-66. See also S Anandhi, 'Reproductive Bodies and Regulated Sexuality: Birth Control Debates in Early Twentieth-Century Tamil Nadu' in Mary E John and Janaki Nair (eds), *A Question of Silence? The Sexual Economics of Modern India*, Delhi, 1998, pp 139-66.
 - 13 Cf the very different interpretation of Gyan Prakash in *Another Reason: Science and the Imagination of Modern India*, Princeton, 1999.
 - 14 On medical philanthropy, see Maneesha Lal, 'The Politics of Gender and Medicine in Colonial India: The Countess of Dufferin's Fund, 1885-1888', *Bulletin of the History of Medicine*, 68, 1 (1994), pp 29-66.
 - 15 Rockefeller Archive Centre, Archives of the Rockefeller Foundation, New York, Record Group 2, 1945, Series 464, Box 306, Folder 2076.
 - 16 Government of India, *Report of the Health Survey and Development Committee*, Vols 4, New Delhi, 1946 [henceforth *Bhore Report*], Vol 1, p 17.
 - 17 Wellcome Contemporary Medical Archive Centre, London (henceforth CMAC), Janet Vaughan Papers, GC 186/6. Memorandum by the British delegation [typescript], 20/1/1945.
 - 18 *Bhore Report*, Vol 1, p 21.
 - 19 *Bhore Report*, Vol 2, chapter 3.
 - 20 Famine Inquiry Commission, *Report on Bengal*, Delhi, 1945. The commission argued that: "If a public health organisation is to be capable of meeting emergencies, it must reach a certain degree of efficiency in normal times. In Bengal the public health services were insufficient to meet the normal needs of the population and the level of efficiency was low", p 116.
 - 21 K Santhanam (Madras), *CAD*, Vol 5, part 3a, August 20, 1947, My emphasis.
 - 22 R Ray (West Bengal), *CAD*, Vol 7, part 5a, November 9, 1948.
 - 23 H N Kunzru (United Provinces), *CAD*, Vol 5, part 6, August 25, 1947.
 - 24 This departed from the quite explicit invocation of rights in the NPC's pre-war documents, which were explicit about the "right to health". More recently, of course, the Supreme Court has interpreted the right to life as including a right to healthcare. See Francis Coralie Mullin vs The Administrator, Union Territory of Delhi (1981) 2 SCR 516; Parmanand Katara vs Union of India (1989) 4 SCC 286; Paschim Banga Khet Majoor Samity vs State of West Bengal (1996) 4 SCC 37.
 - 25 National Archives of India, Ministry of Health files, F 9-4/47-PH (II), Part I, Report by C Mani, IMS, India's Representative to the Interim Commission of the WHO, November 1946.
 - 26 The National Archives of the UK, Public Record Office, DO 35/3764: World Health Organisation - Regional Organisation, Enclosure: 'Pandit Nehru Inaugurates WHO Regional Committee Session', October 7, 1948.
 - 27 The following discussion of the metaphors of malaria eradication in India draws on Frank Snowden's discussion of the Italian experience in *The Conquest of Malaria: Italy, 1900-1962*, New Haven, 2006, particularly around p 140. See also Susan Sontag, *Illness as Metaphor*, New York, 1978.
 - 28 Government of Madras, *Report on the Health Conditions in Madras State*, 1954, p 24.
 - 29 Phanishwar Nath Renu, *Maila Anchal*, Delhi, 1954; I have followed Indira Jhungare's translation: *The Soiled Border*, Delhi, 1991, p 148.
 - 30 Renu, *Soiled Border*, pp 188-89.
 - 31 Renu, *Soiled Border*, pp 188-89.
 - 32 For the clearest statement of the position, see C E A Winslow, *Cost of Sickness and the Price of Health*, WHO, Geneva, 1952.
 - 33 In 1951, there were an estimated 75 million cases of malaria in India. After the resurgence of the 1970s, the number of cases was approximately 2.7 million in 1981, and has since stabilised at a level of around 2.2 million - however, recent years have witnessed a 50 per cent increase in the incidence of the most lethal, P Falciparum strain. See government of India, *National Health Policy* (2002).
 - 34 Cited in V P Sharma and K N Mehrotra, 'Malaria Resurgence in India: A Critical Study', *Social Science and Medicine*, 22, 8, (1986), pp 835-45, 839.
 - 35 For arguments about Kerala's 'exceptionalism', see R Jeffrey, *Politics, Women and Well-Being: How Kerala Became a Model*, Cambridge, 1992.
 - 36 I owe this point to J Devika (personal communication).
 - 37 Sharma and Mehrotra, 'Malaria Resurgence'.
 - 38 Government of India, *NHP* (2002), § 2.3.2.1.
 - 39 World Health Organisation, Print Archives, WHO Library, Geneva. Stig Andersen, 'Assignment Report', SEA/TB/49 (1963).
 - 40 Sudipta Kaviraj, 'Civil Society', pp 313, 315.
 - 41 Bose, 'Instruments and Idioms'.
 - 42 Mohan Rao, 'The Structural Adjustment Programme and the World Development Report 1993: Implications for Family Planning in India'.
 - 43 Government of India, *NHP*, § 2.3.2.2.
 - 44 Indira Gandhi's address to the Joint Conference of the Associations of Physicians in India, January 1976, cited in Mohan Rao, *From Population Control to Reproductive Health: Malthusian Arithmetic*, Delhi, 2005, p 47.
 - 45 NPC, *Population*, p 14.
 - 46 NPC, *Woman's Role in Planned Economy: Report of the Sub-Committee*, chair: Lakshmi Bai Rajwade (ed), KT Shah, Vora and Co, Bombay, 1947, p 175.
 - 47 Indian People's Health Charter, available at <http://phm-india.org>.
 - 48 For a collection of articles from the Medico-Friend Circle's *Bulletin*, see A Patel (ed), *In Search of Diagnosis* ([1977], 1985); A Bang and A Patel (eds), *Healthcare: Which Way to Go?* (1982).

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